



## VIRGINIA DEPARTMENT OF HEALTH ADAP MEDICATION/LAB EXCEPTION FORM

<b>PATIENT NAME (Last, First, MI):</b>			
<b>D.O.B. (mm/dd/yy):</b>		<b>AGE:</b>	
<b>SEX:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>RACE/ETHNICITY:</b> <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> African American/Black (non-Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian, Aleutian, Eskimo <input type="checkbox"/> Unknown			
<b>HEALTH DEPARTMENT PHONE #</b>		<b>HEALTH DEPARTMENT FAX #</b>	
<b>LOCAL HEALTH DEPARTMENT ADAP CONTACT PERSON:</b>			
<b>PRESCRIBING PHYSICIAN NAME:</b>			
<b>PHYSICIAN PHONE #:</b>		<b>PHYSICIAN FAX #:</b>	
<b>FORM COMPLETED BY (Name):</b>			
<b>TITLE:</b>		<b>DATE (mm/dd/yy):</b>	

<b>MEDICATION/LAB TEST REQUESTED:</b>
<b>REASON FOR EXCEPTION REQUEST (PLEASE REFER TO EXCEPTION CRITERIA):</b>

Specify other anti-retroviral medications patient is currently on

NAME OF MEDICATION	DOSE	DATE STARTED	DATE DISCONTINUED

LABORATORY HISTORY [Please start with the most current results (give at least two (2) results if available)]

VIRAL LOAD RESULTS*	DATE	CD4 COUNT RESULTS	DATE

\*For Trofile consideration, viral load MUST be greater than or equal to 1000 copies/ml.

<b>VDH USE ONLY</b>	
<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Denied
<b>Rationale:</b> _____	
_____	
<b>Signature:</b> _____	<b>Date:</b> _____
<b>Date of Positive CCR5 assay/Maraviroc Approval:</b> _____	

*Fax to: Central ADAP office at (804) 864-8050 [Phone: (804) 864-7919]*

Revised 06/09/2008

